MAIL CLAIM FORM TO:

UnitedHealthcare
PO Box 981178
El Paso, TX 79998-1178
Fax: (915) 781-1085 Phone: (877) 311-7849

UnitedHealthcare
A UnitedHealth Group Company

HANFORD EMPLOYEE WELFARE TRUST (HEWT)
FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Please Read These Instructions Before Completing The FSA Withdrawal Request

1. Employee must complete **Part 1.** (If applicable, complete Part 2 "Health Care Expenses" and/or Part 3 "Dependent Care Expenses.")
2. Instructions for **Part 2:**
   A. If expenses were covered by any benefit plan, attach **a copy** of the Explanation of Benefits (EOB) along with your FSA withdrawal form. Your insurance carrier (or a spouse's carrier or an individual plan) should pay before you request an FSA reimbursement.
   B. If expenses are not covered by any benefit plan, attach a copy of an itemized receipt that includes the dates of service, service rendered, and total charge.
3. Instructions for **Part 3:** Attach **a copy** of a receipt that includes the dates of service, day care provider's name, and amount paid to day care provider or attach **a copy** of a cancelled check from the day care provider.
4. Read the Certification For Reimbursement, **sign and date the form. Make a copy** for your records.
5. Mail (or fax) the form to the address (or fax number) provided on this form. Reimbursement requests for a plan year **must be postmarked no later than March 31 of the year following the plan year in which the expense is incurred.**

PART 1 EMPLOYEE INFORMATION (Please Print)

EMPLOYEE NAME (Last and First)	PARTICIPANT ID	DATE OF BIRTH	DAYTIME TELEPHONE NO.
			( ) –
EMPLOYEE ADDRESS		FSA GROUP NUMBER	EMPLOYER NAME
		702633	HANFORD EMPLOYEE WELFARE TRUST

PART 2 HEALTH CARE EXPENSES (Please Print) Please place each expense on a separate line.

PATIENT'S NAME	DATE(S) OF SERVICE MM/DD/YYYY		TYPE OF SERVICE Please check the appropriate box below for each expense(s) MD-medical RX-prescription VS-vision DN-dental HR-hearing	REQUEST AMOUNT
	From:	To:	MD ○ RX ○ VS ○ DN ○ HR ○	$
	From:	To:	MD ○ RX ○ VS ○ DN ○ HR ○	$
	From:	To:	MD ○ RX ○ VS ○ DN ○ HR ○	$
	From:	To:	MD ○ RX ○ VS ○ DN ○ HR ○	$
			HEALTH CARE EXPENSES SUBTOTAL	$

PART 3 DEPENDENT CARE EXPENSES (Please Print) Please place each expense on a separate line.

DEPENDENT'S NAME	DATE OF BIRTH	DATE(S) OF SERVICE MM/DD/YYYY		TYPE OF SERVICE(s)	REQUEST AMOUNT
		From:	To:		$
		From:	To:		$
		From:	To:		$
				DEPENDENT CARE EXPENSES SUBTOTAL	$
				TOTAL REQUEST FOR WITHDRAWAL	$

CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my FSA were incurred by me (and/or my spouse and/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my FSA. I (or/we) will not use the expenses reimbursed through the FSA program as deductions or credits when filing my (our) income tax return.

EMPLOYEE SIGNATURE: DATE:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.